final report of the

MENTAL HEALTH ACTION PROJECT

August 1985

Report of the

MENTAL HEALTH ACTION PROJECT

Rev. Francis Irwin, Chair

Presented to:

The Commonwealth of Massachusetts

Michael S. Dukakis
Governor

Philip W. Johnston
Secretary of Human Services

Edward M. Murphy
Commissioner of Mental Health

August 26, 1985

PUBLICATION OF THIS DOCUMENT APPROVED BY DANIEL D CARTER, STATE PURCHASING AGENT

1M-8-85-806321

ESTIMATED COST PER COPY $1.99

ARCHDIOCESE OF BOSTON
49 FRANKLIN STREET
BOSTON MASSACHUSETTS 02110
(617) 482-5440

SECRETARY FOR SOCIAL SERVICES

Letter of Transmittal

August 26, 1985

To Michael S. Dukakis, Governor of the Commonwealth

Philip W. Johnston, Secretary of Human Services

Edward M. Murphy, Commissioner of Mental Health

I am pleased to submit the Final Report of the Mental Health Action Project. This Report is the product of much hard work and extensive cooperation among the 103 members of the Project. Starting in December, 1984, the members have participated in many subcommittee meetings and have produced recommendations for improving the quality of life and services for chronically mentally ill persons in Massachusetts. There have also been six public hearings, each of which resulted in suggestions that have been incorporated in the Final Report.

The Report contains hundreds of important recommendations. From these, several major themes have emerged as critical to improving services for chronically mentally ill persons. These are:

- High quality, state operated inpatient services, on state lands and in the community, are recognized as an integral part of the continuum of necessary services;
- Families and other informal care givers are among the major providers of services, and the formal service system should support and augment these family efforts;
- Long term residential settings in addition to the more traditional residential program models are necessary for many chronically mentally ill persons in the community;
- Progress has been made in developing community mental health services, but significant gaps still exist for certain services, particularly emergency services; screening and assessment, case management, and family support and respite services;

° New resources, management improvements and innovative financing mechanisms will be necessary to achieve the goal of quality services for chronically mentally ill persons as envisioned in this Report of the Mental Health Action Project.

On August 12, 1985, the Project's Steering Committee voted to approve the Final Report and to transmit it to you and the full membership. While every member may not agree with each recommendation, a remarkable degree of consensus was achieved regarding major priorities and policy direction. The members are to be congratualted for the thoughtful and considerate manner in which this important work was conducted. Secretary Johnston, former Commissioner Callahan, and their respective staffs are also to be congratulated for the inspiration, leadership, and support provided to the Mental Health Action Project.

Sincerely

Francis X. Irwin

Rev. Francis X. Irwin
Chairman
Mental Health Action Project

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ACKNOWLEDGEMENTS

The Mental Health Action Project gratefully acknowledges the many individuals and organizations who have worked cooperatively to support the Project's work and the development of this report.

We must also recongize the staff support provided by both the Executive Office of Human Services and the Department of Mental Health which helped to ensure the success of the Project.

A special note of thanks to James J. Callahan, Jr. who while Commissioner of the Department of Mental Health provided the Project with direction by clearly articulating the key questions which needed to be answered through the Project's work.

Cover design by Pat Attenau, courtesy of the Division of Capital Planning and Operations.

Lastly, special thanks to Reverend Francis Irwin for his able leadership in guiding the entire Project.

MENTAL HEALTH ACTION PROJECT

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Mental Health Action Project

Introduction

Paul is a handsome, intelligent and gifted thirty year old. At age nineteen, while in his second year of college, he was diagnosed as having schizophrenia. He entered the best psychiatric hospitals in New England where after six and a half years, treatment was unsuccessful. With family funds spent and insurance no longer available, he was admitted to a state hospital and later placed in a variety of community programs. His last placement was into a boarding house where he was robbed and beaten, too ill for community living and not ill enough for treatment at a state hospital. Today Paul is at home with his parents. His mother and father try their best to care for their son while also trying to hold down full time jobs. Paul's father has a variety of medical conditions and is recuperating from a recent heart attack. Their wish is for Paul to be cared and understood in a supervised residence and day program that would not reject him as "inappropriate". The burden is heavy, and both parents are extremly worrried about their future and especially their son's future.

Linda is twenty-eight years old and has been in jail fifteen times in the past year. According to her mother, she is schizophrenic and refuses treatment and will not have anything to do with the family. Linda will self-medicate herself with alcohol and drugs. At these times her behavior becomes out of control and she is evaluated repeatedly for inpatient hospitalization. Due to her condition, she is often referred to a detoxification facility. However, due to her violent behavior, no detox unit will take her and, subsequently, she spends most of her time in jail instead of receiving care at a mental health facility.

Barbara is a fifty-six year old woman who has spent an indeterminate number of years living under bridges, behind billboards, and in doorways. She was recently brought to an emergency room of a local hospital when neighbors complained of her to the police. After many attempts to have Barbara evaluated, she was consistently refused hospitalization. Finally, she was committed to a mental health facility on the grounds that she was unable to care for herself. After several months of treatment, she was stabilized on medication and had developed a trusting relationship with a supportive therapist. She was ready to leave the hospital. However, no community placement was available. Eight months later she is still hospitalized.

These cases more than adequately describe the pain and frustration felt by those who need or seek mental health care. Throughout history, Massachusetts has long been recognized as a leader in the care and treatment of mentally ill citizens.

It was before the Massachusetts General Court, in 1841, that Dorothea Dix began her national crusade for improved institutions for the mentally ill, and sought the establishment of Worcester State Hospital as the first such institution designed soley for the care of mentally ill citizens. By the 1950's, Massachusetts had thirteen state-operated inpatient facilities housing more than twenty-three thousand citizens. In 1966, the passage of Massachusetts General Law, Chapter 735 began the process of developing a comprehensive community mental health system. The development of this system, coupled with the advent of community psychiatry and the use of psychotropic medications, enabled many institutionalized mental patients to be discharged from large institutions into their natural communities whereby they could lead productive and fulfilling lives.

Today our state inpatient mental health census stands below 2,500, representing over 10,000 admissions on an annual basis. Many chronically mentally ill persons successfully live in communities of their choice. However, we are also painfully aware that while many have thrived, others such as those cases highlighted above have been shuffled about, lacking the guidance, support and treatment necessary for community living. Numbers of chronically mentally ill persons have been lost to streets, prisons, and other less desirable settings. Despite our best intentions, mentally ill citizens remain unserved or underserved. The problem we face today is how the state's mental health system can best serve those most in need. The issues we confront are the issues of philosophy and implementation: how do we develop a system which takes into account all our previous successes and failures so as to develop a mental health system which effectively responds to the dynamic needs of long term mentally ill citizens? This has been the task of the Mental Health Action Project: to confront this issue with a solid understanding of our past, and fresh insight into our future.

II. PURPOSE AND ORGANIZATION

On October 2, 1984, speaking at the tenth anniversary of the Brockton Multi-Service Center, Secretary of Human Services, Philip W. Johnston, called for the establishment of the Mental Health Action Project as a way to end the debate between community and institutional services and focus on the needs of chronically mentally ill persons. Established on December 21, 1984, the Mental Health Action Project comprised 103

Massachusetts citizens who joined together to review the state's mental health system as it serves the chronically mentally ill. The mission of the project was to:

> "Develop a comprehensive action agenda regarding the nature, scope, and system of services to chronically mentally ill individuals within the Commonwealth."

The Project brings together a vast array of individuals and organizations concerned with the provision of mental health services. This includes consumers, family members, providers, commissions, state agency personnel, the judiciary, legislators, business and labor leaders, and representatives of law, medicine, religion and academia.

The work of the project has been dividied into four committees, each responding to one of the following key questions:

1. Who are the Chronically Mentally Ill for whom the Department of Mental Health has a long term responsibility to serve?

2. What types of services should be provided to them and how should such services be delivered?

3. How can current resources of the Department of Mental Health be best utilized?

4. What methods can be used to properly finance such a system?

The Committee on Individual Needs focused on determining who are the chronically mentally ill and what levels of care are appropriate to their needs. The Committee on Services addressed what type of services shall be provided and how such services should be delivered. This included a major focus on the role of inpatient facilities. The Committee on Resources examined how current resources of the Department could be utilized to meet changing client needs. This included a focus on state hospital land and buildings, management, and personnel. The Committee on Finances focused on issues related to system financing, both on state operated and contractual service systems. The work of both these committees is highlighted in Chapter 3. In addition to these four committees, the Project Steering Committee, consisting of all committee co-chairs and at-large members, was established to add direction to the overall work of the project. The Steering Committee also served as a focal point for discussion of implementation issues.

Reports of each committee were compiled into an Interim Report issued in April, 1985. It reflected the findings of each committee and served as a working document which allowed Project members to review the work of other committees, and resolve areas of incongruence and overlap. The Interim Report should be viewed as a companion document to this final report.

The Interim Report was also used as a vehicle for soliciting

public review and comment on mental health issues and the Project's recommendations. Six public hearings were held in Boston, Worcester (2), Danvers, Holyoke, and Fall River. This final report includes significant revisions made as a result of comments received through the public hearing process. Appendix I highlights testimony received during these hearings.

The Mental Health Action Project represents an important attempt to focus attention on the needs of chronically mentally ill citizens. It in no way diminishes the other target populations for whom the Department has statutory responsibility. Services to children and adolescents and to mentally retarded citizens continue to be areas of concern as well. The Project also recognizes that many chronically mentally persons may have other disabilities or dual diagnoses. This would include chronically mentally ill elderly persons, deaf and hearing impaired mentally ill persons, mentally ill/mentally retarded persons, medically ill/ mentally ill, blind persons and chronically mentally ill substance abusers. Such persons may require special services, which although not highlighted in this report, deserve special consideration.

III. EXECUTIVE SUMMARY:

A. Mission Statement

In order for any organization to be effective it must have a clear understanding of what it wants to achieve at any given time. In order for the Department of Mental Health to be effective in serving chronically mentally ill persons, the project believes that it must commit to a pro-active "mission statement" which clearly articulates the overall mission of the Department and its employees. To this end, the project recommends that the following statement be adopted and embraced by the leadership of the Department as its mission statement in serving chronically mentally ill persons.

> "The mission of the Department of Mental Health shall be to maximize opportunities for persons of all ages who experience severe or long term mental illness; to live, learn, and work in the communities of their choice. To facilitate this mission, the Department must ensure the availability of an appropriate range of services designed to meet clients' needs and desires."

The project believes this statement should appear in all official documents of the Department and as part of all employee and volunteer orientation and training. This mission statement shall be complemented by a set of client centered-objectives, which govern the provision of services offered by or through the Department. These objectives include comprehensiveness, accessibility, continuity of care, and equal access.

B. LEVELS OF CARE

The Project has developed a continuum of needs that includes five levels of care which should be available to chronically mentally ill persons. They are:

Level I: Persons who require intensive medical and psychiatric interventions and support in a secure environment that cannot be provided in a community residential setting.

Level II: Persons who need continuous and intensive long term care in a highly structured environment.

Level III: Persons who may need intermittent or continuous long term care in moderately structured environments.

Level IV: Persons who may need intermittent and/or continuous long term care in minimally structured environments.

Level V: Persons requiring ongoing support of services but who are capable of living independently in the community.

C. Numbers of Chronically Mentally Ill Persons

Through its research the project has determined that the number of chronically mentally ill persons is estimated to be between 47,000 and 57,000 persons. The following chart describes the number of chronically mentally ill persons served annually who are "residents" of a particular setting. Residence is defined as a length of stay greater than six months.

Prisons: 847 - 907
State Inpatient Facilities: 2,120 *
Nursing Homes/Rest Homes: 12,480 - 14,580
Community Residences: 2,922
Family/At Home/Independent: 27,800 - 33,400
Streets and Shelters: 1,600 - 3,200
Total: 47,769 - 57,129

D. Balanced Service System

In order to properly implement the mission statement, it is necessary for the Department to develop a spectrum of services which would enable the clients to live, learn, and work in the communities of their choice. In order to accomplish this, the project recommends the development of a balanced service system which includes inpatient, residential, vocational, and support

*An additional 8,000+ individuals use inpatient beds on a short term basis.

services. The Department currently provides a wide range of services across the Commonwealth, though no definitive spectrum of services exists to serve all clients' needs. As a result, clients are often inappropriately served in more restrictive settings than are necessary. The Project believes that the Department must develop a service system which provides a spectrum of services in every area of the Commonwealth. The lack of a true spectrum of services has led to the unequal allocation of resources among the Department's geographic areas. As a result, many citizens lack the comprehensive service system so necessary to meet their mental health needs.

E. Inpatient Care

As part of a balanced service system, the Project recognizes a need for quality inpatient mental health care. The state hospital system must be improved by providing high quality active treatment based on the functional needs of patients, and less reliance on the use of medication alone. This can be accomplished through the development of a centralized administrative and professional organizational structure. Further, the Project recommends that all hospitals meet Title 19 Medicaid certification or accreditation by the Joint Commission on Accreditation of Hospitals (JCAH).

F. Access and Support Services

The Project finds that the current mental health system is is found to be inaccessable by many citizens. There is very often confusion as to which agency is responsible for serving an individual's needs. In order to improve access, the Project recommends that each geographic area of the Commonwealth have available 24 hour, 7 days a week crisis intervention and screening service which should have the mobility to go to the patient whenever necessary. Such screening would provide access to facilities of various types, including respite care and short term inpatient beds, so that the provision of necessary service is not delayed. In addition, the Project recommends the establishment of a case management and individual service plan capacity for those clients who need and desire such a service. A well designed case management system should not only address the needs of the clients but also work to facilitate the clients' access to programs which fulfill those needs.

G. Management and Finance

The effective and efficient use of state resources is critical to the development of a comprehensive mental health system. In order to develop such a system, the Project offers a variety of recommendations concerning the management and finanacing of mental health services. These include: the development of an equitable funding allocation system whereby geographic areas would receive allocations based on adjusted per capita needs; the piloting of both a capitated and voucher payment system; the

use of excess capacity at private hospitals for acute care; the development of performance standards for vendor contracts; and improvements in both personnel and quality assurance systems. The Project further recommends that state hospital buildings and

ands be used first for the needs of chronically mentally ill persons, and second, when no longer directly needed for direct client needs, then such buildings and lands should be used for development purposes which would benefit mentally ill persons.

IV. SUMMARY

> Albert, now 35, was first hospitalized for an acute schizophrenic episode when he was 21. At that time he was admitted to a state hospital, where he stayed for three months. Albert returned to the hospital four more times in the next eight years. In 1979, the state hospital unit was closed and Albert was later admitted to the acute unit of a community mental health center and his stays were reduced to an average of three weeks. With the addition of a day treatment program in 1980, an apartment program in 1982 and a social club in 1984, Albert has found more social support, meaningful activity and a genuine sense of self-worth. Albert has not been hospitalized since 1982 and his outlook is quite positive. He is looking forward to starting a transistional employment job at a community college and is begining to feel like he is part of the community he first left fourteen years ago.

This case illustrates the success that the state's mental health system can have in serving those who have been cast as chronically mentally ill. It is this success that has driven the Mental Health Action Project. This report represents the final synthesis of the Project's work. Since its inception, the Mental Health Action Project has recognized that fundamental problems exist in the State's mental health system. The Project's work is not simply to identify these problems or lay blame, but rather to offer a document which identifies principles which would form the foundation of a newly invigorated and strengthened mental health system. While not all 103 Mental Health Action Project members may agree on each specific solution to be pursued, we are convinced that there is consensus as to the urgency for needed reform and the need for new resources to implement these reforms. Implementation of the principles contained in this report is left both to the Executive and Legislative branches and the larger mental health community. In order for implementation to be successful, the Project asks that its members and all those who are concerned with the provision of quality mental health services to join together to develop a more humane and effective system of services for chronically mentally ill citizens of the Commonwealth.

Chapter One

Who Are the Chronically Mentally Ill?

I. INTRODUCTION:

As the Commonwealth of Massachusetts has sought to develop a comprehensive mental health system, an essential question which has never been fully answered is who are the chronically mentally ill in the Commonwealth and what system of services is necessary to truly meet their needs? The impact of deinstitutionalization, new directions in community psychiatry, and a growing homeless problem have all left this as the paramount question which must be answered in order to provide direction to the state's goal of providing quality care and treatment to those unfortunate citizens who suffer from mental illness. To answer this question has been the primary objective of the Mental Health Action Project.

In order to respond to this difficult question, the Project has sought to delineate and describe the numbers and needs of chronically mentally ill persons residing within the state. While a comprehensive analysis of the Project's findings are included in the Interim Report of the Mental Health Action Project, this chapter summarizes and highlights the committee's work.

II. DEFINITION:

For purposes of the Mental Health Action Project, chronically mentally ill persons are defined as:

> "Those who suffer from a severe mental illness resulting in a substantial disruption of their functional capabilities. Consequently, they require ongoing psychiatric, medical and/or psychosocial rehabilitation services to achieve and maintain their optimal level of functioning."

To further define severe mental illness, the following categories from the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, third edition, American Psychiatric Association) were included:

1. schizophrenic disorders
2. paranoid disorders
3. major affective disorders

Persons suffering from debilitating personality disorders or from organic mental disorders with predominant behavioral manifestions were also included. Persons with a diagnosis of anti-social personality disorder were generally excluded because this diagnosis reflects an assessment of social deviance which usually comes under criminal jurisdiction. In addition, those suffering from organic disorders, whose needs were primarily medical, were also excluded.

Disruption of functional capabilities, as used in the definition, indicates significant disabilities in one or more of the following areas:

1. self care/daily living skills
2. communication and social relationships
3. learning, concentration, and attention
4. capacity for independent, self-directed, self-sufficient living.

III. ESTIMATING THE NUMBERS OF CHRONICALLY MENTALLY ILL PERSONS:

The key to counting the number of chronically mentally persons was to identify the major settings where they reside, and to estimate the number of persons in each location and the level of care needed by each individual. To achieve an unduplicated count, residence was defined as a length of stay of more than six months.

The Project assumed that many persons reside in settings that may be inappropriate. As a result, a continuum of care was proposed which would allow for patients to move to more appropriate settings. The following represents the five broad categories of service needs within that continuum:

LEVEL 1: Persons who require intensive medical/psychiatric treatment, intervention, support, and maximal security that cannot be provided in a community residential setting.*

LEVEL 2: Persons who need continuous and intensive long-term care in a highly structured environment which may be provided in a community residential setting.

LEVEL 3: Persons who may need intermittent and/or continuous long-term care in moderately structured environments which may be provided in a community residential setting.

LEVEL 4: Persons who may need intermittent and/or continuous long-term care in minimally structured environments which may be provided in a community residential environment.

LEVEL 5: Persons who require ongoing supportive services but are capable of living independently within the community.

* A distinction is made between level 1 maximal security and the level of security connoted by criminal justice involvement in the most restrictive setting possible.

Furthermore, it should be emphasized that chronic mentally ill persons capable of residing at levels 2-5 may require intermittent, short-term hospitalization in "acute beds". To ensure that persons are maintained in the least restrictive residential setting, we are assuming that the numbers of acute beds will be adequate.

According to the principles in this report it is anticipated that as many people as possible will be provided services in levels 2 through 5. As a result the projected capacity for level 1 may be modified. The development of comprehensive community services should occur in several phases, and over time should have a direct impact on the numbers initially projected for level 1.

IV. DISCUSSION OF CLIENT NEEDS BY LOCATION:

The following section serves as a brief analysis of client needs. Determination is made based on the current location or residence of clients. The purpose of this analysis is to highlight those instances where clients may be receiving inappropriate care. In many cases a complete analysis would necessitate individualized assessments as referenced in Chapter 2.

A. Correctional Settings - An estimated 366-386 individuals currently residing in correctional settings are believed to be chronically mentally ill and in need of long term intensive care. Of this number, some proportion will continue to require maximum security. In such cases, it is incumbent upon the Corrections Department to ensure that intensive mental health services are available. Another 184 individuals are thought to need community residential services when they are no longer in need of maximal security. Approximately half of these people are currently at Bridgewater State Hospital and the other half scattered throughout the state and county correctional system.

B. State Hospitals and Community Mental Health Centers- Twelve hundred clients have been identified as long

term clients currently residing in state mental health hospitals and community mental health centers.* An additional 105 individuals are estimated to need long-term care after an acute admission or repeated acute admissions, while another 500 persons are in need of level 2,3,and 4 residential services. (See Chart on reconfiguration of level 1)

C. Private Hospitals - It is estimated that 220 people are residing in private mental health hospitals for longer than six months. Because not enough information was available, no assumptions were made as to what level of care would be needed by this group or whether they could be better served in another setting.

D. Nursing and Rest Homes - The range of chronically mentally ill persons residing in nursing homes is estimated to be between 10,000 and 12,700. An additional 1880 reside in rest homes. Given the prevalence of organic brain syndrome and cognitive disorders among this group, it is difficult to determine the accuracy of these numbers or what mental health services need to be provided in these settings. It is not known how many of these persons would be more appropriately served in other settings. This is an area for which the Project recommends that further research be conducted (see Chapter 4).

E. Department of Mental Health and Private Community Residences - All of the 2,922 individuals residing in community residential programs are assumed to be appropriately placed. This does not imply that everyone in community residences is satisfied or in the precise type of setting he/she might need. While some may occasionally need acute inpatient services, it is believed that their hospitalization will be short, and that they will be able to return to the community

F. Families/At Home/Independent Living - Of the categories discussed, least is known about the chronically mentally ill who are currently residing with families or in independent settings. Approximately 30,000 - 40,000 are thought to reside in Massachusetts, but it is not known to what extent they are counted elsewhere, or what services they require. Again this is an area where further research is needed (See Chapter 4).

*An additional 8,000+ individuals use the hospital on a short-term basis.

G. Streets and Shelters - Between 1600 and 3200 mentally ill persons are estimated to be homeless. Of these, approximately 9% are considered to be in need of level 1 care, 24% level 2 care, 18% level 3 care; 31%level 4; 18% level 5.

Within each level of care various groups have special needs that require different types of services. These special populations include the elderly, adolescents, the medically ill/mentally ill, dual-diagnoses, deaf persons, and cultural/linguistic minorities. In addition to the level of security or level of skilled care indicated for the overall population, unique specialized needs must also be considered. Chapter 2 specifies a comprehensive and balanced system of services which should be available in order to begin to meet the diverse needs of chronically mentally persons.

V. LIMITATIONS OF THE DATA:

As with any project of this scope, limitations were found in data collection which impact the results of this study. In many cases, some of the data bases were not organized according to diagnosis and/or disability. Others did not use standardized definitions and therefore could not be compared. In some settings, such as in nursing homes and rest homes, and in families, information about chronically mentally ill persons was inadequate. Furthermore, in most settings these data had rarely been organized according to needs. In these latter situations (e.g.prisons), the Project relied heavily on the clinical judgment and opinions of members of the Committee on Individual Needs. Project members feel strongly that data base improvements and further research and study is needed to improve the state's ability to analyze needs and therefore initiate system improvements.

VI. SUMMARY:

While the Project has attempted to quantify for planning purposes the unmet needs of the chronically mentally ill, the numbers and labels used in this report tell us very little about who these people are, and what they feel is important. It fails to tell us what their lives are like and how they experience their illness. It is difficult to capture the quality of pain and frustration that a mentally ill person and his/her family may endure. This Project can however raise further questions whose answers will lead to an improved system of services for chronically mentally ill persons within the Commonwealth.

Chapter Two

Services to Chronically Mentally Ill Citizens

I. INTRODUCTION:

The Project believes that a network of mental health services must exist within the Commonwealth which provides a balanced system of high quality inpatient and outpatient services. High quality and accessible services are necessary to successfully implement the mission statement set forth in the beginning of this report.

II. PRINCIPLES:

Project members believe that the following set of principles must guide the development of a balanced service system.

A. Comprehensiveness - A wide range of services are needed so as to be responsive to varying client needs and client choice;

B. Accessibility - Services should be located within relatively easy traveling distance for every client who needs them, and with access into the source system being available 24 hours, 7 days a week;

C. Continuity of Care - An ongoing client-care giver relationship should facilitate client movement from one service element to another as client needs change;

D. Equal Access - There should be a non-discriminatory admission and treatment policy; no client should be denied services on the grounds of age, sex, race, religion, or economic status.

In order to meet these objectives, the Department of Mental Health must develop a full spectrum of services throughout the Commonwealth. In keeping with the mission statement proposed earlier, these services must be designed and administered so that clients of the mental health system can live, learn, and work in the communities of their choice.

III. ACTIONS AND RECOMMENDATIONS:

The following are the recommendations of the Mental Health

Action Project concerning the provision of services to chronically mentally ill individuals:

A. ACCESS TO SERVICES:

The Project found that access to the state's mental health system is difficult. Very often those in need, or those wishing to aid persons in need, do not know who to contact in order to seek assistance. In order to improve access to mental health services the Project recommends the following actions be taken.

1. Income - Income should not be a barrier to the receipt of high quality mental health services for the chronically mentally ill. The system must be designed to provide services to all patients regardless of their ability to pay. Most importantly, the system must be funded at a level adequate to provide services to all who require them.

2. Single Point of Entry - Access to a source of mental health services within each area, particularly during crisis, should be simple and direct and facilitated by a well advertised "front door" which provides for a single and direct point of entry into the mental health system.

3. Telephone Access - In each area or other relevant geographic region, there must be a single well publicized telephone number which would reach an organization equipped to render assistance in case of crisis. Such emergency telephone access must be available 24 hours a day, 7 days per week.

4. Trained Personnel - All persons who deal with clients in need of help should be specially trained to provide helpful and sympathetic assistance. Such training must be ongoing. In addition, clients must be guided and assisted with consistency through the necessary procedures that will determine and respond to their needs.

5. Screening - Each area or community should have a triage or screening service to provide prompt response in a crisis. The service must be available on a seven day, twenty-four hour basis, and should have the mobility to go to the patient whenever necessary. Screening should normally be required before admission to a state hospital, and include a standardized assessment of medical needs.

6. Involuntary Care - A broader range of services should be developed for the involuntary patient. All persons in need of involuntary care do not necessarily require

the same level of services. The development of high level forensic evaluation and medium secure programs within the DMH service system will eliminate the need for commitment to facilities with greater security than necessary, or facilities which are a greater distance from the patient's community.

7. Transportation - Service delivery contracts of the Department of Mental Health must include the provision for transportation to and from such services (including state hospitals and community mental health centers), so as to ensure adequate access for all, especially those in rural areas.

8. Special Populations - The department must ensure that access to services is available for those special populations who require additional assistance. This includes services for deaf clients including highly trained sign language interpreters and the availability of TTY equipment. In addition, services should be designed so as to offer peer support and interaction for such special populations.

B. SERVICES BASED ON INDIVIDUAL NEEDS:

In order to be truly responsive, the service system must be based on the individual needs of clients. In order to accomplish this the Department must develop an individual service capacity for all clients which identifies:

1. The client's major goals with respect to the environments in which the client wishes to live, learn, and work;

2. The tasks or functions the client needs to be able to perform in order to achieve these goals;

3. The supportive resources the client needs to have in order to achieve these goals.

Individual services provided to the client must be based on an individual service plan. Likewise, the types of new programs which DMH creates should be a function of the individual service plan. Thus both DMH itself, as well as the interventions for any one individual client, are shaped by the needs of the recipient of services. It is primarily from the perspective of the client that one sees the need for growth and changes, not just for clients in the system, but for the Department as well.

Consistent with the mission statement articulated earlier, services provided by the department must be based on individual needs and should be designed to:

1. Ensure that the person spends as short a time as possible as an inpatient.

2. Ensure that the person's basic human needs for food, shelter, medical care, meaningful work (or activities) and a network of friends are met.

3. Ensure that the person (re)gains the physical, emotional and intellectual skills needed to function in the community;

4. Ensure that the person has the necessary supports which would help him/her function in the community.

5. Ensure that the person receives adequate medical and psychiatric care with emphasis on reducing the use of medication.

It is imperative that an individual service plan system be developed so that a minimal amount of written material is necessary to succesfully identify, track and manage the client's needs. While the Project found merits in the individual service plan system developed by the Department for mentally retarded individuals, it believes that that system is too complex and could be streamlined for mentally ill clients without compromising the needs of clients and caregivers, and the need for accountability.

C. CASE MANAGEMENT:

The effective provision of services is dependent on continuity of care. In order to ensure such continuity, the Mental Health Action Project recommends the establishment of a case management system for those clients who need and desire such a service.

Case management must be recognized as a vital component of client treatment. A well designed case management system must not only address the needs of the client, but also work to facilitate the client's access to services which will address those needs. This may well be accomplished by a case manager or trained case management aide who personally follows through on the client's needs as identified by the client assessment. As with any service to be provided, case management must also respect the rights of those clients who choose not to participate in the service.

Such a system should establish a supportive human relationship with each client; provide intermittent supportive counseling with respect to problems of daily living; coordinate, monitor and initiate changes in the agreed upon service plan, and provide continuity for clients as they move through the service system. The case manager should also serve as an advocate for the client vis a vis the mental health and generic service

systems.

D. SPECTRUM OF SERVICES:

Currently, the Department provides a wide variety of services across the Commonwealth. However, no true complete spectrum of services exist to serve client needs. As a result, clients are very often inappropriately served in settings more or less restrictive than are necessary. Clearly, the Department must develop a service system which provides a spectrum of services in every area of the state. The Project believes that the model of services developed as part of the Brewster Consent Decree is but one model which could be replicated across the state. Based on the Brewster Decree, the Project felt that the following program types should be available at a minimum in every area to meet the common needs of large numbers of clients, so that they may LIVE, LEARN, and WORK in the communities of their choice. (Note: a complete definition of each service type can be found in Appendix II.)

1. Services Which Enable Clients to LIVE in Their Community:

a. Inpatient Care - The project recognizes the need for well managed inpatient services which will allow clients of the Department to live in the communities of their choice. The need for high quality inpatient facilities which provide active treatment is clear. Such facilities are an integral part of a balanced mental health system. It should, however, not be deemed as the only service available.

Inpatient facilities providing specialized services will be needed during the forseeable future, both long and short term, to serve two critical rehabilitative functions:

(1) Short term acute care, when such care is not available in local community settings; and

(2) Long-term care for those relatively few chronic patients who require continuing security of an institutional setting (whether on a locked or unlocked ward) for their own safety or that of the community.

(See Chapter Four, Management and Finance, Section III. State Hospital Management, for additional recommendations concerning the management of inpatient services.)

The Project believes that the great majority of chronic care patients do not require long-term institutional care. Such care can be best provided in alternative settings of various types. The Project strongly recommends that the creation and

continued availability of a full range of service options must be the cornerstone of the Commonwealth's mental health care policy. It is recognized however, that the availability of community residential programs at the present time is inadequate. Accordingly, for the period of time hopefully brief until adequate community services are developed, the Project recognizes the short-term need to use state inpatient facilities for those chronic patients whose needs may be different from the short term acute or long term care needs as set out above.

b. Other Residential Services - In order to respond to the above, the Project recommends the development of SPECIALIZED RESIDENTIAL FACILITIES within the Commonwealth, including but not limited to the following:

Specialized Home Care
Supervised Apartments
Psychiatric Nursing Homes
Supervised Group Homes
Transitional Apartments
Transitional Community Residences
Apartment Programs with Physical Care Component
Group Residences with Physical Care Components
Apartment Programs with Behavioral Emphasis
Group Residences with Intensive Non-medication support

In addition, the Project believes that chronically mentally ill citizens have been extremely hurt by the lack of affordable housing within the Commonwealth. For this reason, the Project recommends that a concentrated effort be made by the Commonwealth to increase and support independent living opportunities for this population.

2. Services Which Assist Clients in LEARNING in Their Community:

Learning Opportunities - In addition to residing in the communities of their choice, clients of the Department must have opportunities to develop their full potential. This must include the participation in educational, recreational and socialization programs. In order to achieve this goal, the Commonmwealth must commit itself to developing a full network of LEARNING opportunities. This includes, but is not limited to the following program prototypes:

Social Clubs
Recreational/Socialization Programs
Day Treatment Programs
Supported Learning Programs
Day Activity Programs

3. Services Which Assist Clients in WORKING in their community:

Employment and Training Opportunities - In addition to participating in educational and recreational opportunities, chronically mentally ill individuals need to fully develop their work potential. In order to accomplish this goal, the Commonwealth must develop meaningful VOCATIONAL REHABILITATION TRAINING and EMPLOYMENT opportunities. This includes, but is not limited to the following program prototypes:

- Prevocational Training
- Sheltered Employment
- Competitive Employment
- Supported Work Programs

The Project recommends that vocational training opportunities be developed for all levels of care, including opportunities for those at the inpatient level. The Project further recommends that there be greater coordination between the Department of Mental Health and the Massachusetts Rehabilitation Commission (MRC) in developing a continuum of vocational training and employment options for mentally ill citizens. MRC has developed a collaborative and creative relationship with private industry which has enhanced job training and employment opportunities for disabled workers. While a large segment of MRC's caseload includes mentally disabled persons, the expertise of MRC should be fully utilized in serving the chronically mentally ill.

4. Services Which SUPPORT the Clients Attempts to Live, Work, and Learn in Their Community:

Support services - In order to sustain a client in his/her ability to work, live, and learn in the community, it is often necessary to provide certain SUPPORT services. These include, but are not limited to the following:

- Screening and Assessment Teams
- Family Support Programs
- Medication Unit/Nursing Support
- Crisis Intervention Unit
- Case Management
- Short and Long Term Psychotherapy and Counseling Programs
- Respite Care services
- Companion Programs

5. Consumer-Run Living, Learning, and Work Alternative:

Consumer-Run Programs - The Project finds merit in the development and implementation of CONSUMER-RUN mental health services. Such services include, but are not limited to the following:

Residential Peer Support
Crisis and Respite Homes
Drop-in Centers
Teleconferencing Information and Support
Social Clubs

IV. SUMMARY:

The development of each of the above services is essential to the provision of a true continuum of services for clients of the state's mental health system. To develop one set of services over another only dilutes the effectiveness that each component service would have in treating the chronically mentally ill person. It is for this reason that the Project recommends the development of a balanced service system which provides meaningful opportunities for chronically mentally ill persons. Without a balanced service system, coordinated by a strong case management, services will be piecemeal and will not offer the level or continuum of care necessary to meet the needs of chronically mentally citizens of the Commonwealth.

Chapter Three

Managing and Financing The State's Mental Health System and Resources *

I. INTRODUCTION:

The provision of high quality mental health services in Massachusetts necessitates a quality administrative and finance system to support client needs. With this in mind the Project has reviewed the current management and finance systems used by the Department of Mental Health. This Chapter outlines the conclusions of that review and recommendations for the improvement of such services. The overall goal of the committee exploring this area was to design a management and finance system which would maintain clients in the most appropriate setting and insure the most economical and quality care.

In reviewing current management and finance systems the Project has assumed the following:

A. Financial resources available to support services for the chronically mentally ill must compete with a variety of other human needs for services by the citizens of Massachusetts. Therefore, resources for the chronically mentally ill will continue to be scarce and must be allocated and spent in the most cost effective fashion.

B. Due to a variety of historical factors, there are vast inequities in the current allocation of resources across the state. This results in differences in access and quality of mental health resources on a geographic basis.

C. The state needs to plan for a continued use of back-up state operated facilities for the chronically mentally ill.

D. There are a variety of diverse viewpoints within the Commonwealth about the optimal management structure of services. There is no one model or structure of services which will fit each geographic area within the state.

*This chapter contains the recommendations of both the Committee on Resources and the Committee on Finance.

II. PRINCIPLES:

The Project believes that the following set of principles must guide the development of an effective management and finance system.

A. The allocation of Department of Mental Health funds should be made to geographic areas by population with an adjustment factor for need (e.g. socio-economic and demographic needs).

B. Geographic service areas and corresponding institutions need to be of sufficient size to achieve economies of scale, specialization of functions and professional support systems.

C. Program design for chronically mentally ill individuals should provide incentives so as to maximize resources and funds from all sources. (e.g. emphasis should be on maximizing third party reimbursements.)

D. Services should be structured so as to provide performance incentives and penalties for providers with as much freedom of choice as possible allowed for consumers.

E. The financial system should assure accountability for money, clients and quality care.

F. A centralized state hospital administration should become the primary management vehicle for reconfiguring hospital services in order to provide acute, back-up and specialized units.

G. Any planning for developing additional beds should start with residential beds, whether on state hospital grounds or not, so as to alleviate the current stress on acute care beds. Planning for new acute care beds should occur at a later date.

H. State hospital services should be organized to meet the functional needs of patients.

I. Quality assurance and monitoring systems should place the highest priority on establishing a data base that would allow the Department to measure client outcomes. Monitoring systems should ensure that clients receive high quality services in the least restrictive settings.

III. ACTIONS AND RECOMMENDATIONS:

The Project sets forth the following as specific actions and recommendations in order to implement the above principles:

A. FINANCING STRUCTURE:

1. Geographic Allocation of Funds - It is suggested that the Department of Mental Health phase in over a three-year period base allocation of funds for essential services such as intake, assessment and emergency services on a per capita basis with an adjustment factor based on area need. It is suggested that at the end of three years, the maximum variance allowed for any area would range between 80% and 120% of its target. It is assumed that new monies will be necessary for areas to reach their target. An evaluation of the use of existing resources should also be done before resources are reallocated to achieve area targets. (The need adjustment formula should be revised every three years, considering socio/economic factors and other revenue sources).

   It is suggested that this process be accomplished by a maximum shift and/or allocation of funds of 25% of the difference between the target and actual during each of the three years. Additionally, costs per service modality should also be established and allocated to geographic areas on the basis of client usage.

2. Area Allocation of Beds - The Project recommends that a pilot project be undertaken to establish an allocation method by which areas would access inpatient beds. A geographic service area would receive an allocation of inpatient beds according to past usage and possible demographic population adjustment. Any additional use of inpatient beds would necessitate purchase of those bed days from another geographic area or from the hospital. Areas using less than the allocation would receive funds from other areas' purchases. The hospital and area would share in the proceeds and penalties. Hospital and community accounts would be pooled in each geographic area. The Project suggests that this method be piloted in fiscal year 1986 at one or two state hospitals and their corresponding areas.

3. Service Structure - The Project suggests that a combination of competitive and regulatory forces need to be established with the provider system in order to increase quality, consumer satisfaction and fiscal efficiency, while maintaining clinical planning. The project suggests two pilots:

   a. A voucher system - It is suggested that a pilot program be instituted in July, 1986 in the Boston area. Clients would be certified according to certain criteria including past usage of service, and eligibility to receive service from any of a

variety of accredited systems. The provider would be reimbursed according to class rates (e.g. day treatment, residential, emergency, outpatient, etc.).

b. Capitated System - It is suggested that over the next year planning be undertaken to establish a system of capitated funding for Department of Mental Health services to chronically mentally ill persons (similar to a mental health health maintenance organization). Geographic areas would be given funding on a per capita basis for essential and emergency services. The data base developed as a result of the Lynn Union Hospital Study and others like it would be utilized to determine a limited number of client categories and corresponding yearly costs per client. Consumers would elect to have services delivered by the provider of their choice. An enrollment period would be devised during January or February, with a shift of provider to take place the following July for a period of one year. Providers would receive the appropriate amounts of money in their budgets to serve clients who chose them. Providers which lost client enrollment would have corresponding budget reductions. It is hoped that such a system would provide an incentive for providers to serve the most difficult clients, while offering a cost effective service system which provides freedom of choice to the client.

B. AREA MANAGEMENT:

1. Size and Number - The Project suggests that a combination of The Executive Office of Human Services, Department of Mental Health and outside citizen and consumer groups review the existing area boundaries taking into account such factors as population size, density, and access to transportation, plus administrative costs and economies of scale.

2. Area Coordination - In order to meet the complete needs of clients, the Executive Office of Human Services must ensure that there is coordination among all human service agencies at the area level. Interagency cooperation at the client level is essential in order for clients to receive entitlements and other service needs.

3. Area Director's Role - In order to be effective in their management roles, the responsibilities and authority of area directors must be clearly defined. As management responsibility for inpatient units is

transferred to hospital administrators, the relationship of the inpatient service to the area-based system should be clarified.

C. STATE HOSPITAL MANAGEMENT:

1. Chief Operating Officers - The Department of Mental Health should immediately appoint chief operating officers at each state hospital. Such officers should have management authority for the operation and reconfiguration of the hospital system.

2. Full Range of Services - Each hospital must provide a full range of therapeutic services consistent with the client's individual service plan. A therapeutic community should be developed on hospital grounds which provides appropriate services and housing to meet client needs. This should include appropriate medical, psychiatric, residential, rehabilitative, recreational, social and vocational services. Appropriate medical services must be available to all. Such care should be standardized so that all clients receive adequate levels of care. Discharge of patients must be carefully planned, so that clinically appropriate resources, including aftercare and follow-up services, are available immediately upon discharge.

3. Certification - All inpatient facilities of the Department of Mental Health should meet the appropriate standards of the Joint Commission on Accreditation of Hospitals (JCAH), and or Title XIX Medicaid certification. A cost benefit analysis should be undertaken to determine the potential net gain from meeting either Title XIX or JCAH accreditation. Once units are certified, DMH should make every effort to maximize third party revenue through aggressive billing and collections procedures. Toward this end, the Administration should develop a managerial incentive program which allows facilities to retain revenue generated.

4. Staff to Patient Ratio - The Project recommends an effective minimum staff to patient ratio of 1:7 to 1 for all inpatient facilities. However, the Project recognizes that the actual ratio must be based on the needs of patients as determined by service plans and the standards of the accrediting or certifying bodies.

5. Private Hospital Utilization - The development of discrete acute psychiatric units within community hospitals in lieu of state hospital acute units should be actively pursued. The excess capacity of medical/surgical beds within the Commonwealth could be reduced by using such beds as DMH leased, operated, or

contractual acute units. This would provide local certifiable space for the Department's acute care needs, while offering an important option for those hospitals wishing to increase capacity. In addition, private hospitals, especially general hospitals, must be obligated to live up to commitments made in their determination of need (DoN) applications to serve their communities and longer term patients. DoN and other regulatory procedures should be amended to provide incentives to hospitals to serve such clients. No patient should be discharged from a hospital bed unless a transfer has been negotiated or appropriate community placement made. At the same time, the state's more limited responsibility for patient care must be defined.

6. Professional Standards - Professional standards should be developed and implemented for all disciplines (social work, psychology, occupational therapy, rehabilitation counseling, etc.) within the state hospital.

D. PERSONNEL:

1. Recruitment - A centralized effort is needed within the Department of Mental Health to recruit qualified employees, including former patients, into the state hospital and community mental health system. Such recruitment efforts should be made in conjunction with professional organizations, labor unions, and local colleges and universities. In addition, the Department must take steps to foster staff longevity. This should include adequate salary levels in both state operated and contracted programs, career ladders, and clear programmatic goals. Unreachable program goals often result in job dissatisfaction, burn-out, and high turnover.

2. Orientation and Training - Thorough staff orientation and training must be provided for all employees. Such training must commence with employment and should include the technical aspects of each position as well as the overall mission of the Department. Inservice training should help on a continuous basis, be of high caliber and reflect state-of-the-art concepts. Training should also be provided for those employees reassigned to community programs.

3. Job Function and Benefits - Functional job descriptions must exist for all employees within the Department. Where necessary, civil service job titles should be redefined to match job functions. Career ladders should be developed for both professional and non-professional employees within all DMH

organizational structures. All employees covered by civil service should continue to maintain their status whether they move in or out of institutions or community programs. In addition, employees who perform the same job function should be remunerated, regardless of the location of the program, or the status of the employer.

4. Performance Evaluation - Performance evaluation procedures must be developed for all employees. Such procedures must ensure at least a yearly review of the employee's performance in relation to specified job duties, including, where appropriate, responsibility for patient care. In addition, the inappropriate use of sick time, industrial accident and other leaves should be carefully reviewed on a regular basis and proper disciplinary action taken where necessary.

E. QUALITY ASSURANCE:

1. Development of Quality Assurance Systems - The Department of Mental Health must develop quality assurance and monitoring systems for the provision of mental health services both in state hospitals and community programs. Such systems should place the highest priority on measuring the appropriateness and effectiveness of direct client care. The use of qualified professionals, independent citizen amd family advocates are essential to an effective monitoring system. Monitoring should occur at all levels of the system, and should be coordinated across all state agencies which may have monitoring and evaluation responsibility.

2. Performance Standards - Performance standards and procedures for all managers should be developed and implemented to insure accountability for the services and resources under such management control. Such a system must be supported by an automated data base and management information system. Services which are delivered by the Department through contractual vendors must also have clear programmatic standards and criteria. Performance contracts should be the structural mechanism used to negotiate with service providers in order to meet specific quality of care standards. Variables of performance should include client/family choice and satisfaction, incentives for serving difficult clients, efficiency and outcome measures which include some assessment of improvement in quality of life.

   The Project recommends that the Negotiating Committee of the Council of Human Service Providers and the Executive Office of Human services develop such a contract for pilot use in fiscal year 1987, in at least

three rural or suburban areas. (For urban areas, the voucher system, as described earlier, allowing competitive market forces more power is suggested. However, this does not rule out adoption of performance contracts as an additional mechanism.) Monitoring systems must ensure that private vendors serve the chronically mentally ill as part of their service systems.

3. Minimum Standards - The Department must guarantee that minimum standards exist for all service components. Licensing procedures should be implemented statewide to ensure compliance with the Department's community mental health licensing standards.

4. Advocacy and Human Rights - Patients and clients of the Department must have available to them an advocacy and human rights system which answers questions, mediates differences, and promotes informed consent. Such a system must be readily accessible in both inpatient and community programs.

F. RESEARCH AND EDUCATION:

1. Research - The Project recommends that the Department, in collaboration with public and private colleges and universities, place a greater emphasis on research. State funds could be used as a vehicle for leveraging federal and private research dollars. Research areas should included epidemiology, etiology, brain research therapeutic methods and outcomes, and administrative management. Any and all research conducted by the Department must include proper safeguards which protect clients' rights.

2. Community Education - Community education forums should be held regularly across the state to educate the public about the needs of the chronically mentally ill and thus help to reduce the stigma of mental illness. Such forums should include participation by consumers, families and professionals, and serve as a vehicle for educating the public about the work of the Department.

G. USE OF STATE HOSPITAL LANDS:

1. Planning - In order to best utilize state hospital lands for the chronically mentally ill, a comprehensive planning process is necessary to project both patient need and potential use. Each hospital campus must be reviewed to assess current utility, building condition, reuse potential, and cost benefit analysis for renovation or replacement. Where necessary, a choice portion of all hospital lands must be reserved and maintained for a continuum of programs for individuals

who require inpatient, residential, and therapeutic services on hospital grounds. The exact amount of land reserved should be determined by careful assessment of the needs of current residents, and careful estimates of future needs. All buildings and land not used for this group of clients could be developed for alternative residential and commercial purposes that seek to reduce the stigma and promote the integration of persons with mental illness.

2. Reuse of State Lands - Any reuse of state hospital buildings and grounds must seek to answer the following questions: a) How can the land be best utilized to benefit the direct programmatic needs of chronically mentally ill citizens?; and b) If there are no direct programmatic benefits, what other economic or other benefits can be obtained through reuse which will serve chronically mentally ill citizens? Such benefits could be realized through a variety of economic mechanisms such as sale, lease, and exchange. It is essential that such benefits and revenues equal or exceed the real market value. The leasing of land is preferred over sale to maximize long-term gain. The concepts of 1) reverse infill (developing residential communities which integrate housing for mentally ill persons), and 2) linked-development should be pursued when considering alternative uses. For example, development of residential and commercial space could include a set aside of housing units or employment and training opportunities for mentally ill persons. It is suggested that the Massachusetts Land Bank trust be approached for assistance in developing a possible model and mechanisms for carrying out this combination of objectives. It is suggested that at least two hospitals and their surrounding areas be targeted for a joint state and community planning process which would assure the availability of land available for programming and redevelopment during fiscal year 1986.

H. COMMUNITY SITING:

Siting Initiatives - In order to encourage the maximum disbursement of needed residential housing units and to insure a balance between siting residential units on hospital grounds and within community locations, the Executive Office of Human Services should re-examine legislative issues regarding community residence siting laws and take positive steps to reduce barriers which impede the development of new community programs.

Chapter Four

Areas For Further Research and Study

I. INTRODUCTION:

While the Mental Health Action Project has attempted to identify the broad needs of chronically mentally ill citizens in the Commonwealth, there are many issues which the Project felt required further study than was possible given the structure and time frame within which it worked. For this reason, the Project recommends that further research and study be conducted on a variety of issues as outlined below.

II. CHRONICALLY MENTALLY ILL PERSONS RESIDING WITH FAMILIES:

Further research be conducted into the numbers and needs of chronically mentally ill persons residing with families. Specific questions to be examined include:

A. How many chronically mentally ill citizens in the Commonwealth are residing with family members and what are their service needs?

B. What kinds of programs should be developed to support families so that they may better care for family members and avoid institutionalization?

C. Of chronically mentally ill persons residing with families, what number would benefit from alternative living arrangements and what range of living arrangements would be most beneficial?

III. CHRONICALLY MENTALLY ILL PERSONS RESIDING IN REST HOMES AND NURSING HOMES:

The Individual Needs Committee recommends that further research be conducted into the needs of chronically mentally ill persons residing in rest homes and nursing homes. At present there is no adequate mechanism for data collection regarding the large number of persons in these settings. The Project recommends that the Departments of Public Health, Mental Health, and Elderly Affairs collaborate in studying the needs of this group and develop appropriate service plans. (See recommendations of the Long-Term Care Report included in the appendix of this report.)

IV. TREATMENT ISSUES FOR CULTURALLY DIVERSE GROUPS:

The unique treatment issues of diverse cultural groups in need of mental health services should be further explored by the Department of Mental health. The conceptual framework governing therapeutic interventions needs to be re-framed in order to acknowledge the paramount importance of cultural influences on the development of personality and concepts of mental health.

V. SUBSTANCE AND ALCOHOL ABUSE AND MENTAL ILLNESS:

Proper research needs to be done in order to develop treatment concepts and management approaches to deal effectively with those who have a dual diagnosis of chronic mental illness and substance abuse. Persons who have such a diagnosis have historically had treatment needs which crosscut several human service agencies. The result has been a lack of clear agency responsibilty for this needy population. This group also represents a large percentage of the state's homeless population. The problems of this group defy traditional boundaries of either mental illness or organic brain disease and therefore require new thinking and research to seek effective treatment solutions.

VI. HOUSING FOR CHRONICALLY MENTALLY ILL PERSONS:

The Project has found housing to be a major need for chronically mentally ill persons. Often, traditional housing programs have failed to respond to this vulnerable population. In order to respond more effectively to this need, the Project recommends that a technical assistance group be established to explore avenues for developing and supporting long-term housing initiatives, and to propose innnovative strategies toward removing obstacles which inhibit progress in this area.

VII. CHRONICALLY MENTALLY ILL PERSONS WITHIN PRISON SETTINGS:

The Department of Mental health and the Department of Corrections must further study that portion of the prison population identified as having major mental illness. Specific attention should focus on strategies for determining appropriate placements either within the mental health or corrections systems. Both departments must ensure that there are appropriate services available for those discharged from such settings.

VIII. MEDICALLY ILL AND MENTALLY ILL INDIVIDUALS:

The Department of Mental Health must continue to identify those clients of the Department who require both psychiatric services and chronic and acute medical care. In association with the

Department of Public Health, appropriate services must be available for this population.

X. ONGOING DATA COLLECTION:

In order to plan effectively to meet the future needs of chronically mentally ill persons, it is imperative that the state have at its disposal current "state of the art" data concerning:

A. Treatment modalities
B. Psycopharmacology
C. Epidemiology
D. Environmental studies
E. Demographic projections
F. Brain Research

The Department of Mental Health should serve as a clearinghouse for this information and foster pilot projects and research which would enhance future planning efforts.

VIII. MANAGEMENT STUDIES:

The Project recommends research on the following management issues in order to implement fully the recommendations of this Project:

A. Public vs. private provider has long been an issue in the delivery of mental health services. While the Project finds merit in both types of systems, this issue requires further study to determine the most effective service delivery system for specific program and service types.

B. The development of a comprehensive mental health system within the state will necessitate decision making with regard to eligibility for state-supported programs. In order to respond properly, the state must research issues of entitlements and fee structures.

C. Over the last several years the Department of Mental health has made tremendous progress in establishing an effective data retrieval system. In conjunction with and support of civil liberty and patients' rights groups, the Department should work on the development of a data retrieval system. This information base would be of enormous benefit in identifying where clients get lost in their efforts to receive treatment. It would also enable the Department to conduct longitudinal studies to determine the effectiveness of treatment modalities.

Chapter Five

Report of the Subcommittee Studying Massachusetts General Law Chapter 123 (Commitment Statute)

Charge: To review MGL Chapter 123 and assess whether changes in the law would benefit the mentally ill in Massachusetts and if so to recommend changes in the law.

Membership:
Mitch Greenwald, Esq.
Amy Durland, Esq.
Robert Weber, Esq.
Henry A. Beyer, Esq.
Mary Kay Leonard, Esq.
Louis M. Aucoin, Esq.
Richard Ames, Esq.
Mary Jane Moreau
Ken Landon, AMI
James McDonald, AMI
MartyCohen, EOHS
Irene Lee, EOHS
Bernard Katz, M.D., M.P.S.
Mona Bennett, M.D., Chair

Meetings:
June 04, 1985 2:00 - 4:00 PM
June 21, 1985 1:00 - 2:00 PM

Conclusions: After four hours of very active discussion and review of reference materials (including APA Model Commitment Law, summaries of Commitment Law in other States) the membership of this group agreed to represent majority and minority positions.

Majority Position: A large majority of those present at each of the meetings favored recommending no change in the existing statute. Examples of problems around commitment of mentally ill persons raised in our meetings were felt by the majority to represent problems in practice rather than defects in the law. The provision in current Massachusetts Law to commit for risk of serious harm resulting from impaired judgement was considered equivalent to the "gravely disabled" provision in statutes in other states. Furthermore, the majority felt that a change in law to permit involuntary commitment for necessary treatment, however phrased, would not be allowed under the U.S. Constitution.

Minority Position:

A small minority of those present at each meeting felt that possible changes in commitment statutes in Massachusetts should be explored, and that this would need to be a long range deliberative process far exceeding the time frame of the M.H.A.P. The minority, therefore, recommends that a committee of interested people be established to explore changes in MGL Chapter 123, particularly to permit:

1. Commitment for necessary treatment for persons who might not be in physical danger;

2. Commitment to other treatment levels, in addition to hospital care, such as day treatment , outpatient, etc., and;

3. Shortening of the length of time a person may be held involuntarily before a court review of involuntary commitment.

Attached please find a position paper written by James E. McDonald of AMI of Massachusetts, elaborating on the position held by a minority of Subcommittee Members.

MINORITY REPORT

Submitted by James E. McDonald
A.M.I. of Massachusetts

As the legal advocates state, there is no need for a change, but we as families of the mentally ill know there must be other standards than "dangerously" used.

It is obvious to the families and many clinicians throughout the state and also the country that there is a serious gap in the commitment law for those patients who are obviously psychotic, in need of, and likely to benefit from treatment, but not yet deteriorated to the point of being dangerous. These patients, who have severe major mental illness have stopped taking medications that in the past have been useful to them; but because of major mental illness, lack the capacity to make an informed decision concerning treatment. They are obviously and seriously ill persons and given time will certainly deteriorate to either qualify for commitment as being dangerous or else be "criminalized" by being locked up in jail as a disorderly person or some other charge.

We cannot let these patients be pushed to the suicidal or homicidal stages. It is happening too often.

There is no question that a spectrum of services from outpatient treatment through inpatient hospitalization through community support programs are required in every community, but it is clinically unrealistic to assume that with the presence of such programs, each and every patient will avail themselves of those treatment programs voluntarily. All families and clinicians support voluntary treatment for the mentally ill whenever that is possible and do whatever they can to encourage the person to seek such treatment voluntarily. But, there exists a number of patients, because of the very nature of mental illness who will not seek treatment voluntarily, and if the criteria for commitment requires physical dangerousness, either the patient will remain untreated until they deteriorate to qualify under one of those criteria or locked up on some minor charge simply to get them into the stream of treatment. There is obviously that ill patient who is so sick as to be incapable of consenting to treatment, and this is the person who must be cared for. These people are "dying with their legal rights on."

The freedom to be wandering on the streets, psychotic, ill, deteriorating and untreated when treatment would be effective as it had in the past, is not a freedom, it is abandonment. The liberty of the right to be seriously and obviously mentally ill but needing to deteriorate to being dangerous before treatment can be given is not a right, it is an insensitivity cruelly presented as concern.

On listening to Robert Weber legal advisors when talking about those who complain to them, they probably don't know the total amount that are seriously mentally ill, and probably a lot less than 01% complain to them.

We feel that a new standard must be put in place. If a patient is dangerous that means police intervention, we get to change this.

The standard would read:

It would enable a person to be involuntarily committed for treatment if it is found that the person is mentally ill, and is unable to make an informed decision regarding treatment. No findings of physical dangerousness is needed. The person must show substantial probability of serious mental or emotional deterioration unless treatment is provided, and the person must be incapable, because of mental illness of understanding the advantages and the disadvantaged of accepting treatment and alternatives have been explained to the person.

Appendix I

Summary of Public Comments

I. INTRODUCTION:

The following is a summary of commments received relative to the Interim Report of the Mental Health Action Project issued in April of 1985. These comments were generated mainly from five public hearings held during May of 1985. These hearings were held at: Bristol Community College, Fall River; Gardner Auditorium, Boston; Hogan Regional Center, Danvers, Worcester State Hospital and University of Massachusetts Medical school, Worcester.

Testimony and comments are organized according to the four major subdivisions of the Mental Health Action Project: Individual Needs, Services, Resources, and Financing.

II. INDIVIDUAL NEEDS:

A. On the question of the number of persons requiring "level one" care, there was a continuous and unresolvable debate ranging from virtually no need for "institutional"beds to a projection of 4000 in the state who will require custodial care for the rest of their lives, including about 1800 who will require secure (locked) settings. Others felt that if the state were to serve these people in the community there would not be the necessity for the current level of 2400 beds which now exists. The number of persons that the Mental Health Action Project found needing level 1 care falls within these parameters.

B. There was considerable comment on the lack of inpatient beds available for those in crisis and the enormous unmet need of chronically mentally ill persons living at home and on the streets who cannot easily gain access to mental health services. Many felt that acute inpatient beds must be available when needed, and unthwarted by restrictive admission procedures which are based at maintaining census levels.

C. Many people took issue with the use of "place of residence" as a criterion for counting the population. It was also considered dehumanizing to describe people as a category of "chronically mentally ill" rather than as individuals.

III. SERVICES:

A. Psycho-social and rehabilitative programs with vocational

training were strongly recommended as more effective modalities than other more traditional psychotherapeutic models of treatment. Many felt that social clubs should be a standard model throughout the Commonwealth, because of its effectiveness in enhancing self esteem and fostering social rehabilitation.

B. There was considerable comment suggesting that a separate section of the Project final report should be devoted to the elderly and their needs while residing in nursing homes, at home, and in institutions. There is a large number of mentally ill elderly who at present cannot find reasonable residential placements because of the lack of appropriate psycho-geriatric homes. (See recommendations of the Long Term Care Report included at the end of this appendix.)

C. The concept of therapeutic communities was highlighted by members of the Alliance for the Mentally Ill of Massachusetts. They recommend that the following services be available in all service areas and in theraputic communities located on each of the eight state hospital grounds: 1) long-term housing with supervision for continuum of care; 2) transistional housing; 3) 24 hour, 7 day a week mobile crisis intervention, outreach to where crisis occurs, with prompt response; 4) respite care; 5) case management for a continuum of care; 6) availability of day treatment and social clubs; 7) progressive vocational rehabilitation training facilities with meaningful work opportunities; 8) proper citizen monitoring of all services. In addition, the group recommends that EOHS encourage research into the biological and physiological factors causing long-term mental illness; that the DMH appoint staff persons in each area whose sole responsibility is to develop and expand programs and services for those stricken with long-term mental illness; that EOHS, DMH, and DPH develop public education to destigmatize mental illness by disseminating information about research, pointing to the biological factors of mental illness and statistics, clearly proving that the mentally ill are no more (in fact less) violent than the population as a whole and more often victims than perpetrators of criminal acts; and that a department of mental illness be established.

D. There was considerable testimony that the report did not address the special needs of deaf mentally ill persons in the Commonwealth and that a special section of the final report should be written to highlight such needs. These include the development of specialized inpatient and outpatient units for the deaf, peer-supported residential options, and interpreter services. (See recommendations of the EOHS Deaf Task Force included at the end of this appendix.)

E. There was considerable comment and testimony which supported the development of subsidized housing as a major priority for chronically mentally ill citizens.

F. There were many suggestions that transportation services must be available to and from programs as a method of improving access to mental health services.

G. Physical plant and staffing were identified as key areas for improvement at state hospitals.

IV. RESOURCES:

A. Strong leadership by the Department of Mental Health was stressed as a way to drive the changes that need to be made in the system, understanding the resistance inherent in traditionally entrenched approaches.

B. A capacity for ongoing monitoring of mental health programs should be developed by an agency outside the Department of Mental Health.

C. Improved data collection by the Department of Mental Health is necessary in order to insure a system of accountability and to insure the quality of existing programs and new initiatives.

D. To avoid fragmentation of services, an interagency coordinating group should be organized at the EOHS level to provide for those people who tend to fall between the cracks of the various service agencies and to ensure that services are client directed.

E. Affiliation with universities and medical schools will enhance morale of staff, provide better training, and prevent burnout through the creative interchange of ideas.

F. State lands are a prime resource which should be utilized in the service of mentally ill persons. The fear that this valuable resource might be squandered or prioritized for other uses was articulated.

G. Many felt that the management of resources needs to be improved within the Department, including the distribution and redeployment of staff, as well as the funding and monitoring of vendor programs.

V. FINANCES:

A. Replace archaic funding mechanisms with flexible, sensible alternatives such as cluster funding and voucher systems.

B. There is insufficient funding within the community system to act on identified licensing deficiencies and thus improve programs.

C. Existing non-DMH funded community residences ,such as those in Fall River and New Bedford, lack any mechanism for funding critical service and capital improvements. Programs that have proven to be successful are endangered as a result of an inflexible contract system.

D. Many felt that task forces in the past have failed to achieve their goals due to the lack of funding for implementation and followup planning and that a similar fate may face these recommendations without sufficient resources for implementation.

E. Some areas with the greatest need get the fewest dollars in the current allocation of DMH dollars. The inequitable distribution of resources throughout the Commonwealth has been cited as a significant problem.

VI. SPECIAL POPULATIONS:

The following summarizes recommendations received by the Mental Health Action Project with regard to mental health needs of the elderly, deaf and hearing impaired persons, and homeless mentally ill persons. Many of these recommendations grew out of the ongoing work of recent task forces studying the larger needs of these populations. While the project did not explore the unique needs of these groups in great detail, it recognizes the importance of initiating planning efforts on behalf of these special populations. Where appropriate, the reports of these task forces should be consulted.

RECOMMENDATIONS CONCERNING MENTAL HEALTH AND THE ELDERLY
(from the Long-Term Care Report, EOEA/EOHS June, 1985)

- The Executive Office of Elder Affairs and the Department of Mental Health should continue their joint research to develop a greater understanding of mental health service needs of elders, to identify geriatric mental health program models in Massachusetts, and gain a better understanding of in-patient and institutional needs.

- The Department of Mental Health should appoint a staff person whose sole responsibility will be to develop mental health policies and programs to serve elders and the Department of Mental Health should include psycho-geriatric services in the state plan.

- The Commissioner of the Department of Mental Health and the Secretary of the Department of Elder Affairs or their representatives should be ex-officio members of the Advisory Councils of the other organization to oversee the coordination of policy development between the Departments of Mental Health and Elder Affairs.

- The State should encourage research on the causes and treatment of mental disorders of elders. Information on the impact of medications on elders is particularly important.

- On the local level, the mental health care system and the home care system should develop better communication, linkages, and coordination to achieve more comprehensive and cohesive services for elders.

- Department of Mental Health Area Boards should be encourage to have elder representation and Home Care Corporations should be encourage to have mental health representation.

- Home Care Corporations and mental health care providers should train their staff who directly serve elders on psycho-geriatric issues.

- Department of Mental Health Service Areas should offer training, consultation and education to Home Care Corporations, nursing homes, rest homes, and community health care providers, such as Visiting Nurse Associations, on geriatric mental health care.

- All Department of Mental Health service areas should be encouraged to have specialized geriatric teams with training and expertise in mental disorders of elders. Specialized geriatric services should include: outreach services, case management, day treatment programs, and counseling services.

- All Home Care Corporations should develop memoranda of understanding with corresponding local mental health care providers.

- In each of the Department of Mental Health service areas, a geriatric psychiatrist should be available to evaluate elders at home. This would greatly enhance the functioning of the elder protective services system and provide needed service to abused elders.

- All Department of Mental Health Areas should have twenty-four (24) hour emergency services and Home Support/Family Relief services accessible to elders and their families.

- Specialized Alzheimer's day care centers should be developed throughout Massachusetts if the results of the demonstration program are positive.

- Senior centers should be encouraged to develop peer counseling programs.

- The Department of Public Health should examine special needs of elders for substance abuse service programs.

- The Department of Mental Health's area-of-tie policy, as it effects nursing homes residents, needs to be examined with a goal of improving elders' access to mental health services and to insuring continuity of care.

- A special commission should be established by the state for the purpose of making an investigation and study of mental health services for the elderly.

RECOMMENDATIONS CONCERNING MENTALLY ILL DEAF PERSONS
(from the EOHS Task Force on Deafness Report, July, 1985)

1. Identify and develop individual service plans for deaf and hearing impaired individuals in DMH programs, institutions, community residences, nursing homes, prisons,and other residential settings and day programs, with particular emphasis on communication factors.

2. Develop one centralized hospital-based inpatient/outpatient unit for deaf adults and one for deaf adolescents, utilizing the same professional staff (skilled in sign language and knowledgeable about the sociology and psychology of deafness) and specialized ward staff.

3. Develop a range of specialized residential options for deaf and hearing impaired people whose primary or exclusive communication system is sign language. Group deaf individuals together in the same residence and employ staff who are competent in American Sign Language and knowledgeable about deafness.

4. Assure the existence of at least one outpatient mental health service in each DMH district in which specialized professional staff are available who are competent in American Sign Language and in which interpreter services are readily provided when needed on a 24 hour basis. Each such program should also develop linkages to acute short-term inpatient or evaluative services utilizing outpatient staff and interpreters to the greatest degree possible for communication, access to treatment and information.

5. Develop an interpreter and specialized clinical response system statewide for: emergency screenings in hospital settings; for response to emergencies involving police proceedings; and crisis interventions of any kind.

6. Train judges, public defenders, legal advocates as well as key staff in the criminal justice system about deafness, interpreters, and resources for rehabilitation so that deaf law offenders who may be mentally ill or emotionally disturbed will have access to complete communication. This is especially crucial in legal commitment proceedings, in psychological evaluations associated with such proceedings, and during periods in prison or in diagnostic placements in institutions.

7. Develop a system that allows funding for individual client needs independent of area affiliation. Policies and procedures need to be revised to ensure the most efficient and humane delivery of services to deaf clients of the Department of Mental Health.

RECOMMENDATIONS CONCERNING HOMELESS MENTALLY ILL PERSONS

Of the 8-10 thousand homeless individuals in Massachusetts, the estimated range of chronically mentally ill persons is 30-60%, depending on whether dual diagnosis of substance and alcohol abuse is included in the estimate. At the low estimate of 30% (of 8000 homeless persons statewide), we are talking about 2400 chronically ill homeless persons in the streets and shelters for whom some responsibility is indicated. 1/3 of this number is estimated to be episodic first time users of the shelters, whose needs must be differentiated from the more permanent "chronic" shelter and street population.

For the "acute" or first time users of the shelters there should be one or two facilities in each region identified to be crisis intervention or triage centers, focused on assessment and counselling, with the primary goal of preventing the homeless condition from becoming chronic.

The Community Mental Health Centers need to develop a welcoming front door, with a non-judgemental, non-threatening approach to treatment. This requires a fundamental shift of attitude and committment towards working with this group.

Mobile crisis teams are needed to assist shelter staff in emergencies with guests in need of acute hospitalization and assessment of other services.

Direct access to short hospitalizations should be available. At present there is a severe problem in the communication between the shelters and the impatient units. This should be addressed at a policy level, including clarification of policies related to discharge from inpatient units to shelters.

For the more permanent or chronic shelter population (20% of which has been estimated in studies to have been homeless for 2 years or more) there should be the following services:

I. LONG TERM:

Planning towards increasing the network of affordable low cost housing with varying levels of management/supervision, and elaboration of a case management system to help people maintain their maximum level of independence .

II. SHORT TERM:

A. Outreach to shelters from the area mental health centers. This outreach must be developed as an intrinsic part of the treatment planning. The Mental Health Centers must recognize responsibility for the mentally ill in the streets and shelters who remain untreated for reasons of resistance, both on the part of the mentally disabled person as well as on the part of the helping system.

B. Transitional shelters-which provide people with their own beds, providing some stability and consistency. At present the emergency shelters operate on the first come first serve basis, which is not a satisfactory model for this group of clients. The transitional shelters could offer on site counseling and assistance in obtaining benefits.

C. Pre-vocational training and other social rehabilitative programs-

In general, the services targeted for the population which is chronically mentally ill and homeless are not substantially different from the generic continuum of services for chronic mentally ill persons in other settings. This population by definition, is system-dependent, and requires concrete, specific case management interventions to optimize social functioning. The lack of community connections, and the lack of "significant others" dramatizes the problems faced by this vulnerable group in its efforts to survive and cope in a harsh environment.

It is evident that the the condition of homelessness aggravates the course of mental illness, as well as in many instances, causes its occurrence. Unless the primary social welfare needs of stability, safety and survival are addressed, there cannot be an effective solution to treatment of the mental health problem. As Dr. Elvin Semrad so poignantly stated, "You cannot cure appendicitis by putting a salve on your big toe."

Appendix II

Spectrum of Services Program Definitions

A. Service which assist clients in LIVING in their community:

Inpatient Programs - To provide short term or emergency hospitalization for persons who are in crisis and who cannot be served at the time in other DMH residential, day, or crisis intervention programs. See Section VII.

Specialized Home Care Program - Supervised living of one to three adults in a private home in the community. Home care providers supervise and assist in activities of daily living, home management skills, utilization of community resources, etc.

Supervised Apartment Program - A community-based residential program providing structure and supervision to adults living in apartments. Supervision and teaching of daily living skills are provided to assist clients to move to less restrictive settings.

Supervised Group Home - A small community based group living facility providing room, board and supervision in daily living skills for persons in need of long term maintenance.

Transitional Apartment Program - A community based transitional apartment program with a maximum of four persons per apartment, operating 24 hours a day providing room, broad, and supportive services including supervision and intensive training in daily living skills. Residents are usually expected to move to a more independent and/or less intensive living situation within one year.

Transitional Community Residence - A community based living facility operating 24 hours a day providing room, board and supportive services including supervision and intensive training in daily living skills. Residents are usually expected to move to independent and/or less intensive living situation within one year.

Apartment Program with Physical Care Component - A community based apartment program with a maximum of four persons per apartment that provides daily assistance and training in basic activities of daily living and physical care for clients with high A.D.L. needs.

Group Home with Physical Care Component - A community based living facility providing room, board and daily assistance and training in minimal behavioral problems and high A.D.L. needs.

Apartment Program with Behavioral Emphasis - A community based apartment program with a maximum of four persons per apartment providing room, board and intensive services within the apartment for persons with serious behavioral problems. The program is designed to replace problemmatic behaviors with appropriate living skills so the individual may move to a less restrictive, more normalized environment. Residents will have low physical care needs.

Group Home with Intensive Support and a Non-Medication Emphasis - A small community based group living facility for persons who might otherwise have been hospitalized during a crisis period. Medication is deemphasized an an intensive interpersonal approach is emphasized.

B. Services which assist clients in LEARNING in their community:

Social Clubs - The purpose of a social club is to provide membership in a community; to provide companionship and friendship; to provide recreation; to provide a setting for social skill development. The focus of a club is to provide a stress free environment for individuals to enjoy social activities and find companions while developing skills and a support system.

Recreactional/Socialization Program - Funds should be provided to community centers, YMCA, YWCA or adult education programs utilized regularly by 10 or more DMH clients living in DMH housing or in non-DMH housing, to provide one extra part-time staff liaison and necessary membership or free tuition.

Day Treatment Programs - Day treatment programs provide a structured, five day a week, day time program including psychiatric services, individual and group therapy, milieu therapy, medical services, educational services, and social and vocational rehabilitation on a relatively short-term basis directed to individual treatment goals.

Day Activity Programs - Day activity programs consist of a daily, five day a week, structured program of social, educational, vocational, rehabilitation and activities of daily living training oriented to individual services plans and goals of clients, including both those requiring a short term transitional service and others requiring a longer term maintenance service.

Supported Learning Programs - Post secondary carer education program conducted on a college campus. Designed to teach students how to selet, plan and prepare for successful participation on an educational or vocational environment of choice. Provides necessary supportive services to help students cope successfully in the college setting.

C. Services which assist clients in WORKING in their community:

Prevocational Training - Prevocational training provides a structured employment setting for the teaching of basic work skills to persons not yet able to perform independently in a sheltered workshop. Such skills would include hygiene, grooming, attendance, behavior towards supervisors, attention span, etc. Typically prevocational programs are part of other programs (clubhouses, day activity, day treatment) and do not offer pay but may have travel or other stipends.

Sheltered Employment - A sheltered workshop provides vocational training and rehabilitation services by accquiring through private industry sub-contract jobs. Training may be targeted for specific jobs such as assembly, electronics and clerical work. Training takes place in sheltered workshop, work station in industry, or similar settings. These settings are also appropriate for extended employment (i.e. ESEP). Participants are paid sub-minimum or sub-scale wages based on productivity.

Supported Work Programs - work training program conducted on-th-job in a business or industry setting. Designed to teach trainees the particular skills needed to succeed in the actual job in which they have been placed. Provides necessary supportive services to help each trainee cope successfully with the demands of their particular work environment.

Competitive Employment - Competitive employment provides advanced training through real jobs in the community at full competitive wages. Job placements help clients locate and continue independent employment. Typical programs are TEP (Transitional Employment), supportive work, job club, and permanent placement.

D. Services which SUPPORT the client in their community:

Screening Team - A program designed to provide initial screening, assessment and service planning for all at risk persons to annually or more frequently review and update the clients service plan.

Family Support Services - Family support services consist of specific, short-term training and behavior management skills help which is provided to families of DMH clients who are living at home, with a relative, foster family or in specialized home care.

Medication Unit/Nursing Support - A program designed to evaluate, in conjunction with the Assessment Team, the need for medication for all at risk DMH clients in the Area, to prescribe and monitor medication for those clients who require it, and to provide supplementary home nursing visits for those persons having physical health care needs related to medication.

Crisis Intervention Unit - A program designed to provide crisis intervention on a 24 hour a day, 7 days a week basis for up to five days, 24 hours a day, to clients both new to the DMH system and those already receiving DMH services.

Case Management - Case management involves responsibility for establishing a supportive human relationship with each client; providing intermittent supportive counseling with respect to problems in daily living; coordinating, monitoring and initiating changes in the agreed upon service plan for a client; providing continuity for clients as they move through various services of the system; and advocating for client vis a vis the mental health and generic service system.

Psychotherapy Counseling Program - Family and individual psychotherapy services will provide regular supportive therapy oriented to the needs and goals of clients and families as a supplement to DMH residential or day services, or as the sole service for some DMH clients.

Respite Care Services - Respite care provides relief for a family from daily care and supervision of a DMH client who is residing in a family setting, whether natural family, relative, foster family, or other types of specialized home care. Respite care may extend from a few hours up to 30 days of care provided in the client's home, in the home of a trained community provider or in DMH community-based housing.

Companion Programs - Persons in danger of institutionalization are matched with companions who assist the person in carrying out activities of daily living, linking with other community resources and supporting the person during times of

Appendix III

Tables and Illustrations

TABLE 1

ESTIMATES OF CHRONICALLY MENTALLY ILL PERSONS COUNTED BY PLACE OF RESIDENCE *

CURRENT PLACE OF RESIDENCE	POPULATION CHARACTERISTICS (or other avail. info)	# PERSONS SERVED ANNUALLY	Comment
State Correctional Institutions*	Chronic mentally ill	320	Source: Subcommittee on Jails. About 210 persons are served annually in the State's five major correctional institutions. In the remaining facilities, approximately 10% of inmates need some form of mental health care.
MCI Framingham	Chronic mentally ill	87	Source: Joyce Murphy, Superintendant, MCI Framingham. Approximately 10% suffer from CMI. Of this group, 1/3 have lengths of stays greater than six months.
Bridgewater State Hospital	low estimate high estimate	430 490	Source: Robert Fein, McLean/Bridgewater Program. Data indicates approximately 600 700 annual admissions are chronic mentally ill persons representing 430 490 individuals per year.
Bridgewater Trmt Center	Sexually dangerous, and psychotic	10	Source: Mann Moncill, Bridgewater Treatment Ctr. Clients' average length of stay is greater than 8 yrs.
**State Mental Institutions and Comty Mental Health Centers	Long-term Acute	1,200 700	Source: Dept. of Mental Health. 1,200 residents have average length of stay greater than 5 yrs. 2/3 of the 8,000 persons admitted annually have been previously institutionalized. Of these, some 700 have lengths of stays longer than 6 mos.
Private Hospitals	Psychiatric Hosp. & Hosp. w/Psych Unit	220	Source: Mass. Hospital Assn. Estimate of the number of individuals in this setting are based on data from McLean Hospital.
Nursing Homes	low estimate high estimate	10,600 12,700	Source: National Center for Health Statistics survey showing 22% of Mass. Nursing Home residents with chronic mental illness.
Rest Homes	Chronic mentally ill	1,880	Source: Dept. Public Health survey of Mass. rest homes.
Community Residences	Receive residential and day services	2,600	Source: Dept. Mental Health.
Private Comty Residences		322	Source: Richard Dodson, M.D.; President, Mass. Council of Comm. Resid. Providers.
With Families/ At Home/Indep.	low estimate high estimate	27,800 33,400	Source: Based on prevalence estimates of chronic mental illness and est. that 50 60% live at home. We estimate that 80% of these remain at home for longer than six months.
Streets & Shelters	low estimate high estimate	1,600 3,200	Source: Dr. E. Bassuk. Estimate that 30 - 60% of the state's 8,000 homeless are chronically mentally ill. Approximately 2/3 of these have been on the streets for longer than six months.
TOTAL -----	low estimate high estimate	47,769 57,129	

* Place of residence is based on 6 months continuous stay.

**It would be anticipated that the numbers could be reduced over time as the development of community placements proceed.

TABLE 2

ESTIMATES OF CHRONIC MENTALLY ILL INDIVIDUALS AND THEIR RESIDENTIAL NEEDS

CURRENT PLACE OF RESIDENCE	POPULATION RANGE	# PERSONS SERVED ANNUALLY	<< LEVEL OF CARE / APPROPRIATE SETTING: LEVEL 1: Long Term Intensive Care	LEVEL 2: County Based with Intensive Staff	LEVEL 3: County Based w/ Moderate Staff	LEVEL 4: Semi-Indep. w/ Minimal Structure	LEVEL 5: Indep. Living w/ Support Services >>
State Correctional Institutions**		320	150 *	170	0	0	0
MCI Framingham		87	66 *	14	7	0	0
Bridgewater State Hospital	low estimate	430	140 *	0	0	0	0
	high estimate	490	160 *	0	0	0	0
Bridgewater Treat Center		10	10 *	0	0	0	0
State Mental Institutions and County Mental Health Centers	Long-term	1,200	1,200	0	0	0	0
	Acute	700	105	140	280	175	0
	(%)		(15%)	(20%)	(40%)	(25%)	
Private Hospitals		220					
Nursing Homes	low estimate	10,600					
	high estimate	12,700					
Rest Homes		1,880					
Community Residences		2,600	0	520	1,560	520	0
				(20%)	(60%)	(20%)	
Private County Residences		322	0	0	322	0	0
With Families/ At Home/Indep.	low estimate	27,800					
	high estimate	33,400					
Streets & Shelters	low estimate	1,600	140	380	290	500	290
	high estimate	3,200	290	770	575	990	575
	(%)		(9%)	(24%)	(18%)	(31%)	(18%)
TOTAL -----	low estimate	47,769	1,811	1,224	2,459	1,195	290
	high estimate	57,129	1,981	1,614	2,744	1,685	575
			(26%)	(18%)	(33%)	(18%)	(5%)

* Some portion of this population will require maximum secure settings (Level .5).

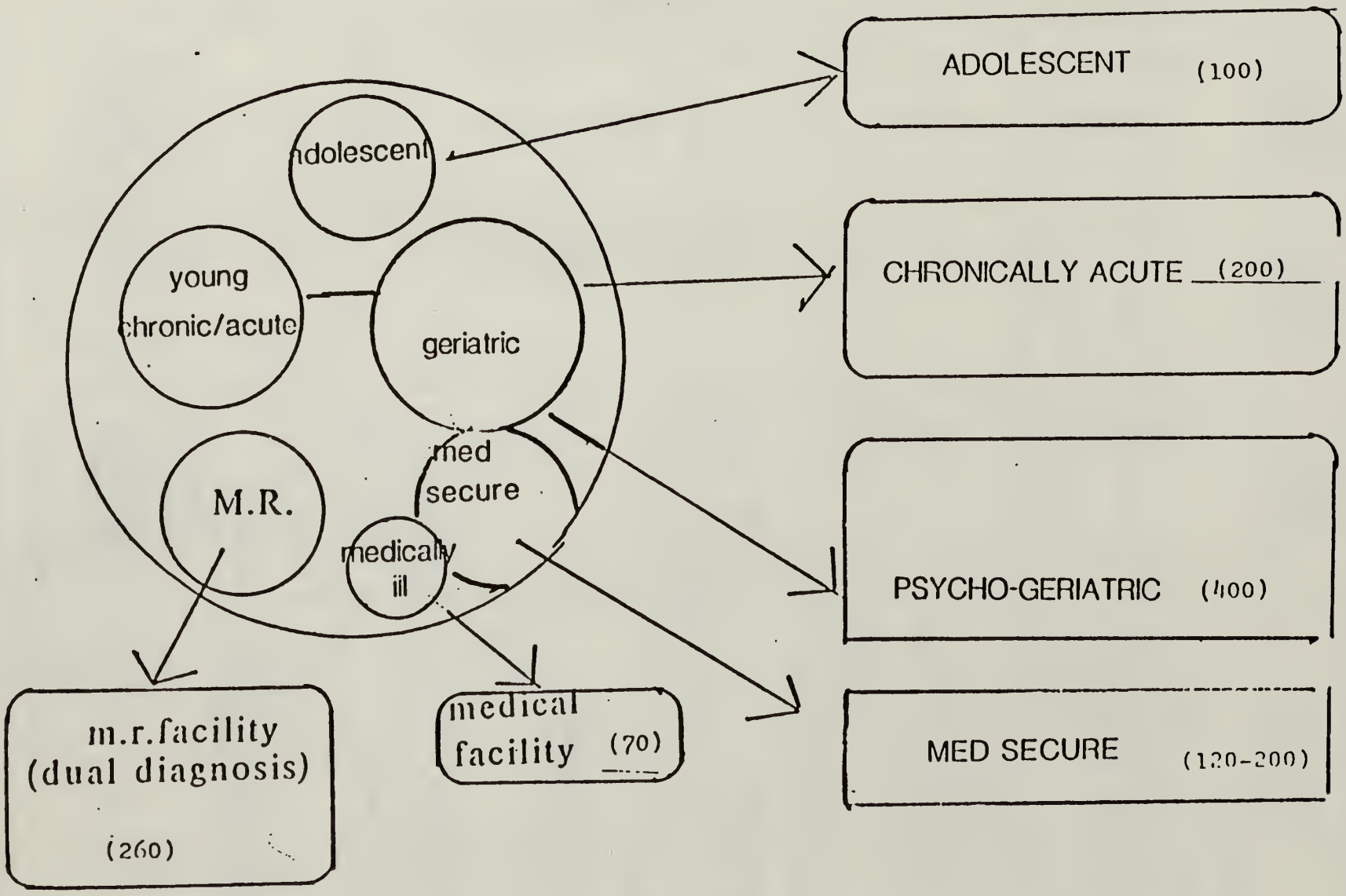
** Does not include county jails

TABLE 3

ESTIMATE OF NEED FOR APPROPRIATE RESIDENTIAL SETTINGS

CURRENT PLACE OF RESIDENCE	# PERSONS SERVED ANNUALLY	# IN APPROPRIATE SETTINGS	# NEEDING ALTERNATIVE SETTINGS
Prison Settings:			
State Correctional Instit.	320	10	310
MCI Framingham	87	0	87
Bridgewater State Hospital	430 - 490	330 - 356	140 - 160
Bridgewater Treatment Ctr.	10	10	0
Subtotal:	847 - 907	350 -376	537 - 557
Hospital Settings:			
State Mental Instit & Commty Mental Health Ctrs.	1,900	1,200	700
Private Hospitals	220	?	?
Subtotal:	2,120	1,200	700
Nursing Homes & Rest Homes:			
Nursing Homes	10,600 - 12,700	??	??
Rest Homes	1,880	??	??
Subtotal:	12,480 - 14,580	??	??
Community Residences:			
Community Residences	2,600	2,600	0
Private Cmmty Residences	322	322	0
Subtotal:	2,922	2,922	0
With Families/At Home/ Independent:	27,800 - 33,400	??	??
Streets & Shelters:	1,600 - 3,200	0	1,600 - 3,200
TOTAL:	47,769 - 57,129	4,472 - 4,498	2,837 - 4,457
Breakdown by level of services required:			
LEVEL ONE:		1,200	591 - 761
LEVEL TWO:		520	704 - 1,094
LEVEL THREE:		1,882	577 - 862
LEVEL FOUR:		520	675 - 1,165
LEVEL FIVE:		0	290 - 575
# REMAINING IN PRISON SETTINGS: (LEVEL .5)		350 - 376	0

RECONFIGURATION OF LEVEL 1



new specialized treatment /therapeutic units

Getting From Here To The Goal: Transitional Planning